TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-16-0731-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
November 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy's bills are not being processed in accordance with to Texas Guideline Rule 133.240 Medical Payments and Denials."

Amount in Dispute: $ 1,143.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: December 9, 2015: "We are in receipt of the above captioned medial fee dispute resolution. The bills have been reviewed again and are being processed for payment."

Response Submitted by: Broadspire, P. O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2014 through July 24, 2015	Pharmacy Services	$1,114.23	$487.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.
3. Neither party submitted an explanation of benefits for the services in dispute.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor due additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

Regarding the date of the service August 22, 2014, the request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 16, 2015. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for the date of service August 22, 2014

The remaining date of service will be reviewed per applicable rules and fee guidelines.

2. The date of service July 24, 2015. 28 Texas Administrative Code §134.503(c) states,

> The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

Date of Service	Name of medication	Reported Units	Amount billed	MAR (AWP per unit) x (number of units) x 1.25 + $4.00
July 24, 2015	Meloxicam 15 mg tablet	60	$348.19	$4.84490 x 30 x 1.25 + $4.00 = $367.37
July 24, 2015	Zolpdem Tartrate 10mg	20	$150.51	$4.62540 x 20 x 1.25 + $40.00 = $119.64
		Total	$498.70	$487.01

3. The maximum allowable for the services in dispute eligible for review is $487.01. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $487.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $487.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.